STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		04/21/2011
		1		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIE	R	l l	LYMPIA DRIVE	
HEARTH	AT WINDERMERE	≣	l l	RS, IN46038	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
R0000					
			7,000		
	This visit was for a State Residential		R0000		
		y. This visit included the			
	investigation of	Complaint Number			
	IN00086625.				
	Complaint Num	ber IN00086625:			
	•	State Residential			
		ed to the allegations is			
	cited at R306	ed to the anegations is			
	ched at K306				
	_	April 18, 19, 20, and 21,			
	2011				
	Facility Number	r: 002999			
	Provider Numbe				
	AIM Number: 1				
	Anvi Number.	NA			
	Survey team:				
	_	NTeam Coordinator			
	Michelle Hostet				
	Rita Mullen, R.I				
	Kim Munch, K.I	(7/10, 17)			
	Census bed type	••			
	Residential114				
		•			
	Total114				
	Census payor ty	pe:			
	Other114	r			
	Total114				
	10ta1114				
	Danidan data	w1 10			
	Residential sam	pie: 10			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

471H11

Facility ID:

002999

TITLE

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE S			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	00	COMPL	ETED
			B. WING	10		04/21/20	011
NAME OF B	AD CLUDED OD CLUDALIED			TREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER		9	745 OL	YMPIA DRIVE		
	AT WINDERMERE				S, IN46038		
(X4) ID		TATEMENT OF DEFICIENCIES	II	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		EFIX AG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
IAU			17	AU			DATE
		al State findings are cited					
	in accordance wi	th 410 IAC 16.2-5.					
	0 -1:4 :-						
Quality review completed 4-28-11							
	Cathy Emswiller	KN					
R0155	(I) The facility shall	I have an effective garbage					
K0133		al program in accordance					
	with 410 IAC 7-24.	. Provision shall be made					
		anitary disposal of solid					
	waste, including di and similar items.	ressings, needles, syringes,					
		ation and interview, the	R015	5	Housekeeping and Food Ser	vice	05/21/2011
		ensure the facility	staff will be inserviced instructing them to make sure the dumpster		03/21/2011		
	_	osed in order to prevent			· · ·		
	•	e of trash, for 1 of 1			lid is closed each time they take out trash. Inservice will be done		
		rved the facility in 2 of 3			by May 20, 2011. Maintenand		
	•	4/19 and 4/21/11.			supervisor will check the		
	ouscivations on -	4/19 and 4/21/11.			dumpster lid each day during		
	Findings include				daily rounds to make sure it is closed. Food Service Directo		
	i mamgs merade	•			check the dumpster several t		
	On 4/19/11 at 9·3	30 A.M., the facility			a week upon entering and ex	iting	
		served positioned on the			the building to ensure the lid	is	
	-	the parking lot, at the			closed.		
	* *	building. The front door					
		pster was open, and both					
		dumpster were open.					
		ash were observed					
	stacked inside up						
	dumpster.	, to the top of the					
	aumpster.						
	On 4/21/11 at 1:4	42 P.M., the dumpster					
		th the front door open,					
		Is were open. At 2:10					
		company was observed					
	, 101000						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		04/21/2011
NAME OF P	ROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP CODE OLYMPIA DRIVE	
HEARTH	AT WINDERMERE		I	ERS, IN46038	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		mpster and leaving the			
	*	open. At 3:30 P.M.,			
		loors were observed to			
	still be open.				
	In an interview d	uring the environmental			
	tour on 3/15/11 a				
	Maintenance Supervisor indicated the				
	-	emptied the dumpster			
	every day except Sunday and Tuesday.				
	J J 1	ft the doors open, and he			
had to shut them.					
	nad to shut them.	•			
	(a) An evaluation of the individual needs of each resident shall be initiated prior to				
R0214					
		all be updated at least			
		upon a known substantial			
	change in the resid	dent 's condition, or more			
		nt 's or facility 's request. A			
	needs of the resident	all evaluate the nursing			
		ation, interview and	R0214	The Director of Nursing will	06/05/2011
		e facility failed to	10211	review each resident's service	
	complete an eval	· ·		plan/assessment to ensure a	
	•	d substantial changes in		reflective of the resident's cu condition. Resident's #83 and	
		nerging behaviors, in a		#105 service plans/assessm	l l
	sample of 10 resi	· · ·		will be update to reflect thier	
	[Residents #83 at			current condition. The Direct	
	Litesiaento 1105 di			Nursing will inservice all staff participate in writting service	wno
	Findings include			plans or assessments on the	
	1 mam55 merade	•		proper procedure and regula	tions
	1. The clinical record for Resident #83			concerning documentation of	
		4/20/11 at 4:44 P.M.		service plans and assessment Nursing staff will be inservice	
	45 10 110 110 410 011	= V/ 11 WV 1. 1 1 1 1111.		that any change of condition	,u
			1	1 ,	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **471H11**

Facility ID:

002999

If continuation sheet Page 3 of 26

´		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
			B. WIN	G		04/21/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
				1	LYMPIA DRIVE		
HEARTH	I AT WINDERMERE			FISHEF	RS, IN46038		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	The resident was admitted to the				should be reported on the 24 report. The Director of Nursir		
	secured/Alzheimer unit from another				will monitor the 24 hour repo	•	
	· ·	10 with diagnoses that			both Keepsake Unit and the		
	included, but wer	· · · · · · · · · · · · · · · · · · ·			Assisted Living unit for chang	ges	
	dementia, depres	sion, and hypertension.			in condition and verify that updated service plans and		
	Incidents reported	d by the facility to the			assessments were done for	,	
		Division of the Indiana			resident that has a change ir condition. All items to be	l	
	1 ~	t of Health included the			completed by June 5, 2011.		
	following:				, ,		
	ionowing.						
	 12/26/10"Poure	ed lemonade over					
		nt's name] head in the					
	_	r to breakfast." The					
	residents were se						
		milies were notified. A					
	family member for						
	1 -						
		ician for follow-up,					
		medication change and					
	urinalysis test for	a urinary tract infection.					
	1/28/11"Per act	ivity director, resident					
		way in room of other					
	1	and smacked her					
	1						
	•	ted. Both residents had					
		Vital signs checked.					
		s notified. [Resident					
	1 -	D. appointment on					
		events reported. [The					
		ame] usually keeps door					
	locked."						
	2/3/11"Residen						
	Resident [residen	ıt's name] apartment.					

002999

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL 04/21/2	
			B. WIN			04/21/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
HEARTH	I AT WINDERMERE			1	LYMPIA DRIVE RS, IN46038		
							710
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
		rkers walking near room					
		nentered room and					
	observed [Resident #83] pull [other						
	_	er wheelchair onto floor					
		g her." Resident #83 was					
		eute hospital geriatric					
	psychiatric unit o						
	1 - 5						
	The "Nurse's Not	tes" progress notes from					
	12/28/10 through 4/12/11 indicated the following:						
	1/21/11 at 7:30 P	.M"Had altercation in					
	main dining roon	n with [other resident's					
	l -	yelling from nurse's					
	station. Altercati	-					
	1/28/11 at 2:40 P	.M"This resident					
	pushed her way i	nto Room [room number					
	listed] and smack	xed resident					
	Separated"						
	2/1/11 at 9:15 A.	M"Resident attempted					
	to grab dietary ca	art when busing tables.					
	Removed from a	rea."					
	2/3/11 at 1:30 P.M	M" Maintenance					
	worker came to [writer]. Reported this					
	resident [#83] wa	as in room [room number					
	listed]. Maintena	ance workers was					
	walking near roo	m, found this resident					
	pulling another re	esident out of her					
	wheelchair and b	egan hitting other					
	resident"						

002999

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPI	
			B. WING			04/21/2	2011
NAME OF I	PROVIDER OR SUPPLIER	8			DDRESS, CITY, STATE, ZIP CODE		
					LYMPIA DRIVE		
HEARTH	AT WINDERMERE			FISHER	RS, IN46038		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		A.M"Resident left at					
9:00 A.M. with [family member] to							
	[hospital]"						
		M"Resident ambulated					
	from car to un	it"					
		M"Resident very					
	agitated upon arrival, would not sit down, trashing dining room place settings, throwing glasses on floor, does not listen						
	to directions, wa	ndering aimlessly. Given					
	Ativan [an anti-a	inxiety medication] and					
	Seroquel [an anti	i-psychotic medication].					
	Finally settled do						
	,						
	3/9/11 at 11:20 A	A.M" has been					
	uncooperative w	ith care and difficult to					
	redirect"						
	3/9/11 at 12:30 F	P.M" [family					
	members] arrang						
		atric] doctor for behavior					
	issues"	acres decreases for contactor					
	155465						
	3/9/11 at 7:00 P	M"Constantly on the					
		id picking at silverware,					
		o run after another					
	J 0,	fe and forkdeterred by					
		ot sit down, does not					
	interact with staf	1, mumbles					
	2/15/11 at 12:10	DM " Wandarina					
	3/13/11 at 12:10	P.M" Wandering					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP: 04/21/2	LETED	
	PROVIDER OR SUPPLIER		9745 O	ADDRESS, CITY, STATE, ZIP CO LYMPIA DRIVE RS, IN46038	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
TAG	about unit and re Going into other their personal ca Has removed her times" 3/15/11 at 6:00 F sitting down con refusing to eat for taking things aparesidents, makes oblivious to other with staff or oth	edirected several times. Is apartments and getting are items, soap, powder. It shoes numerous P.M" very anxious, stantly on the floor, rod, constantly moving, art, picking at other no eye contact, seems are people, doesn't interact ter residents." In 4/20/11 at 5:10 P.M., ated the resident had are, and always has had are in facility. The erved at that time arrse's alcove/station. She and a low tone of voice. ates, she wandered away, and walking around the unit In Evaluation" dated atted in the clinical record. and system used to assident's level of abilities	TAG	DEFICIENCY)	APPROPRIATE	DATE
	_	aluation, following the ges in her behavior, was				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì		NSTRUCTION 00	(X3) DATE : COMPL	
			A. BUI B. WIN			04/21/2	011
NAME OF	PROVIDER OR SUPPLIER	 			ADDRESS, CITY, STATE, ZIP CODE		
				1	LYMPIA DRIVE		
	I AT WINDERMERE			<u> </u>	RS, IN46038		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	DATE
							2111.2
	During the daily	conference on 4/21/11 at					
	11:30 A.M., the Administrator was given the opportunity to submit						
	documentation/e	evidence of an evaluation					
	of the resident fo	ollowing the substantial					
	change.						
	At the final exit on 4/21/11 at 3:20 P.M.,						
	no additional evaluation documentation was provided for review. In an interview						
	1	Director of Nursing					
	1	ad provided "everything"					
	they had.						
	2. In an intervie	w on 4/19/11 at 9:50					
		indicated Resident #105					
	1	usion, and was wandering					
	1	y were concerned about					
	1	ent so they moved her to					
	1	ed Alzheimer's unit few					
	weeks ago.						
		ord for Resident #105 was					
		0/11 at 9:30 A.M.					
	~	ded, but were not limited					
	1	ressure, C.V.A. [cerebral					
		t"stroke"], left sided					
	1	tive impairment, and					
	osteoporosis.						
	A UNI						
		mary" dated 4/1/11					
	Indicated the res	ident was alert, oriented,					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUIL B. WING	DING	00	COMPL 04/21/2	ETED	
	PROVIDER OR SUPPLIER		p. which	STREET AL	DDRESS, CITY, STATE, ZIP CODE YMPIA DRIVE S, IN46038		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE OT OTHE APPROPRIA' DEFICIENCY)	ГЕ	(X5) COMPLETION DATE
	confused, and ha her mental status	d a poor memory with changing often.					
	indicated "the residence of cognimemory loss the redirection for wadded to the cate indicated the residence of his indicated the residence of his indicated "gets was inside of bldg [brown indicated that the behavior 2 to 3 to a substitution of the provide informate interview during 4/21/11 at 3:15 Provide indicated she had	andering" A note gory for "wandering" dent wandered at night. omments" section p at night and wanders ailding]." The form also e resident displayed this mes weekly. conference on 4/20/11 at O.N. [Director of ren an opportunity to ion related to an ident's behaviors. In an the exit conference on e.M., the D.O.N.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/21/2011	
	PROVIDER OR SUPPLIER		9745 C	ADDRESS, CITY, STATE, ZIP CODE DLYMPIA DRIVE RS, IN46038	
	SUMMARY S (EACH DEFICIEN REGULATORY OR (e) Following complete in the services to be provided some services or resident shall be an (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services or and revised as applete resident and fact and revised as applete resident and fact and services or and revised as applete resident and fact and services are in the service plant resident upon required. (A) No identification services provided subsequent to the need for a change (5) If administration provision of resides both, is needed, a involved in identification the services to be Based on observices.	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Deletion of an evaluation, the opriately trained staff entify and document the wided by the facility, as ffered to the individual ppropriate to the: ffered shall be reviewed propriate and discussed by acility as needs or desires acility or the resident may plan review. In service plan shall be by the resident, and a copy shall be given to the plest. In and documentation of its needed if evaluations initial evaluation indicate no in services. In of medications or the intial nursing services, or licensed nurse shall be cation and documentation of provided. Intincipation interview and	9745 C	DLYMPIA DRIVE	06/05/2011
	provide a service to be supplied, re falls, for 4 of 4 re these issues, in a	e facility failed to plan listing the services elated to behaviors and esidents who experienced sample of 10 residents dents #83, #32, #105 and		review each resident's service plan/assessment to ensure a reflective of the services to be supplied to each resident's at that the services address the resdient's current condition. Resident's #83 and #105 serplans/assessments will be u to reflect services offered. To Director of Nursing will inser all staff who participate in wr	all are pe and e rvice pdate ne vice

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

471H11

002999

Facility ID:

If continuation sheet

Page 10 of 26

l i '		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
			B. WIN	G		04/21/2	011
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	ROVIDER OR SUFFLIER			9745 O	LYMPIA DRIVE		
	AT WINDERMERE			FISHEF	RS, IN46038		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TΕ	COMPLETION
IAG			+	IAG		o on	DATE
TAG	Findings include 1. The clinical rewas reviewed on The resident was secured/Alzheim facility on 12/10/included, but were dementia, depression of the transfer	ecord for Resident #83 4/20/11 at 4:44 P.M. admitted to the er unit from another /10 with diagnoses that re not limited to, sion, and hypertension. d by the facility to the Division of the Indiana t of Health included the ed lemonade over nt's name] head in the r to breakfast." The sparated and their umilies were notified. A		TAG	service plans or assessment the proper procedure and regulations concerning documentation of service plans, assessments, and ser offered. The Director of Nurs will monitor the 24 hour repo both Keepsake Unit and the Assisted Living unit for changin condition and verify that updated service plans and assessments were done and they reflect the services need for that resident. All items to completed by June 5, 2011.	s on vices sing rt for ges	DATE
		events reported. [The					
	other resident's n	ame] usually keeps door					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE: COMPL 04/21/2	ETED	
	PROVIDER OR SUPPLIER		p. wiite	STREET A	DDRESS, CITY, STATE, ZIP CODE YMPIA DRIVE S, IN46038	l	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Resident [resident Maintenance wo and heard scream observed [Resident] out of heard began hitting admitted to an acceptance of the "Nurse's Note 12/28/10 through following: 1/21/11 at 7:30 Femain dining room name] Heard station. Altercate 1/28/11 at 2:40 Femain pushed her way listed] and smack Separated" 2/1/11 at 9:15 Acceptance of the station of the st	tes" progress notes from a 4/12/11 indicated the 2.M"Had altercation in m with [other resident's yelling from nurse's ion unwitnessed." 2.M"This resident into Room [room number ked resident M"Resident attempted art when busing tables.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLE	
			B. WIN			04/21/20	711
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
HEVDTH	I AT WINDERMERE			1	LYMPIA DRIVE RS, IN46038		
					NS, IN40036		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
1710		m, found this resident		1710	·		DAIL
		esident out of her					
	^ ~						
		egan hitting other					
	resident"						
	2/4/11 of 11:00 A	M"Resident left at					
		family member] to					
		ramny member j to					
	[hospital]"						
	2/9/11 of 2:45 D M	M "Dagidant ambulated					
	3/8/11 at 3:45 P.M"Resident ambulated						
	from car to unit"						
	3/8/11 at 8:00 P.M"Resident very						
	,	ival, would not sit down,					
	-	oom place settings,					
		on floor, does not listen					
	· ·	ndering aimlessly. Given					
		nxiety medication] and					
		-psychotic medication].					
	Finally settled do	own"					
	2/0/11 . 11 20 4	36 11 1 1					
		.M" has been					
	_	th care and difficult to					
	redirect"						
	2/0/11	3.6 H 50 ''					
	3/9/11 at 12:30 P	-					
	members] arrang						
	1 .	atric] doctor for behavior					
	issues"						
		M"Constantly on the					
	'1 0	d picking at silverware,					
	1	run after another					
	resident with kni	fe and forkdeterred by					

PRINTED: 06/15/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CO	NSTRUCTION 00	(X3) DATE COMPI		
			B. WING			04/21/2	2011
	PROVIDER OR SUPPLIER		974	5 OI	DDRESS, CITY, STATE, ZIP CODE LYMPIA DRIVE SS, IN46038		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID				(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFI	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)	AIE	DATE
	1 - 1	ot sit down, does not					
	interact with staf	i, mumbles					
		P.M" Wandering					
	1	directed several times.					
	1 -	s apartments and getting					
	1 ^	re items, soap, powder.					
	1	shoes numerous					
	times"						
	3/15/11 at 6:00 F	P.M" very anxious,					
	sitting down constantly on the floor,						
	refusing to eat for	ood, constantly moving,					
	taking things apa	ort, picking at other					
	residents, makes	no eye contact, seems					
	oblivious to othe	r people, doesn't interact					
	with staff or other	er residents."					
	In an interview of	on 4/20/11 at 5:10 P.M.,					
	L.P.N. #20 indic	ated the resident had					
	displayed "bizarı	e" behaviors since her					
	admission to the	facility. The resident					
	was observed at	that time standing at the					
	nurse's alcove/sta	ation. She was mumbling					
	in a low tone of	voice. After a few					
	minutes, she war	ndered away, and was					
	observed walking	g around the unit in the					
	hallways.						
	A "Pre-Admission	on Evaluation" dated					
		ated in the clinical record.					
		ng system used to					
	1	sident's level of abilities					
	did not address b	ehaviors.					

Facility ID:

PRINTED: 06/15/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ļ .		NSTRUCTION 00	(X3) DATE : COMPL		
			A. BUII B. WIN			04/21/2	
NAME OF	PROVIDER OR SUPPLIER	<u> </u>	p. (11)		ADDRESS, CITY, STATE, ZIP CODE		
				1	LYMPIA DRIVE		
	I AT WINDERMERE			FISHER	RS, IN46038		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE	DATE
IAU	A Service Plan, of following in the section for "Beharea of care: "Can be uncooped aimlessly at time regularly, but us socks on. Will socks	dated 3/9/11, listed the "Services Provided" havioral/Mood Patterns" erative and wanders es. Removes shoes hally will leave slipper it on floor at times."		IAU			DATE
		w on 4/19/11 at 9:50					
	1	indicated Resident #105					
	1	usion, and was wandering y were concerned about					

002999

l	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COME 04/21/	LETED
	PROVIDER OR SUPPLIER		9745 OI	DDRESS, CITY, STATE, ZIP CO LYMPIA DRIVE RS, IN46038	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
		ent so they moved her to ed Alzheimer's unit few				
	reviewed on 4/20 Diagnoses include to, high blood provascular acciden	rd for Resident #105 was 0/11 at 9:30 A.M. ded, but were not limited essure, C.V.A. [cerebral t"stroke"], left sided tive impairment, and				
	indicated the res	mary" dated 4/1/11 ident was alert, oriented, a poor memory with schanging often.				
	indicated "the is because of cognimemory loss the redirection for we added to the cate indicated the rest A note in the "Co- indicated "gets un inside of bldg [b	andering" A note gory for "wandering" ident wandered at night. omments" section p at night and wanders uilding]." The form also e resident displayed this				
	following for "So the section for "I	ated 3/4/11 listed the ervices Provided" under Behavioral/Mood f care: "Up occasionally				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
ANDILAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILD		00	04/21/2	
			B. WING		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2			LYMPIA DRIVE		
HEARTH	I AT WINDERMERE	:			RS, IN46038		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P.	REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	COMPLETION DATE
IAU	during noc [nigh	· · · · · · · · · · · · · · · · · · ·	+	IAG			DATE
	cooperative usua	-					
		ces to be provided by the					
	facility were not	listed.					
		conference on 4/21/11 at					
	· ·	Administrator was given					
	1	o submit documentation					
		or other evidence related					
		be provided by the					
	facility for the re	esident's behaviors.					
	At the final exit on 4/21/11 at 3:20 P.M.,						
		cumentation of services					
	to be provided re	elated to behaviors was					
	provided for rev	iew. In an interview at					
	that time, the Di	rector of Nursing					
	indicated they ha	ad provided "everything"					
	they had.						
	3. In an intervie	w during the initial tour					
		00 A.M., L.P.N. #5					
		nt #32 had recently been					
		ost weekly. She also					
	indicated resider	nt had a diagnosis of					
	Parkinson's disea	ase.					
	The clinical reco	ord for Resident #32 was					
		9/11 at 1 P.M. Diagnoses					
		re not limited to,					
	osteoporosis, C.	-					
		onary disease], ataxia					
	1 ^	rol of bodily movements-					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
			B. WIN			04/21/2	011
NAME OF	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
HEADTL	I AT WINDERMERE	:			LYMPIA DRIVE RS, IN46038		
				<u> </u>			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΤE	DATE
-	-walking] and ga	· · · · · · · · · · · · · · · · · · ·		-			
	, wanting and go	ar uenemany.					
	The most recent	fall risk assessment					
		cility on 1/17/11 indicated					
	1 -	a high risk for falls.					
		2					
	A "Service Asses	ssment" dated 3/16/11					
	indicated in the	category for "Mobility,					
		t": "Assistance required					
		ransport to and from all					
	meals per wheel	chair"					
	A "Physical The	rapy Evaluation & Care					
	Plan" dated 4/4/1	11 indicated: " Patient					
	is fall risk especi	ally on uneven surfaces,					
	Mod A [moderat	e assist] to prevent falls.					
	Unsteady gait pa	ttern, limited balance					
	reaction ability of	on uneven surfaces					
	without assistive	device. More so when					
	fatigues Decre	eased safety awareness.					
	Increased intenti	onal tremor on upper					
		fatigue. Unable to					
		hree balance strategies,					
	max to mod [ma	ximum to moderate]					
	1	prevent fall without					
	assistive device	" The evaluation					
	indicated resider	nt was a high risk for falls					
	and had decrease	ed ability to transfer.					
		notes indicated that					
		s on following dates:					
		ile trying to use walker					
		nours on the floor because					
	her pendant [use	d as call light for help]					

PRINTED: 06/15/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILD	ING	00	04/21/2	
			B. WING		DDDDGG GWW GWW GWD	04/21/2	011
NAME OF I	PROVIDER OR SUPPLIER	1			DDRESS, CITY, STATE, ZIP CODE LYMPIA DRIVE		
HEARTH	AT WINDERMERE				S, IN46038		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWING BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PF	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	was wrapped aro	ound arm of wheelchair.					
		floor in living room by					
	C.N.A.						
		t of chair and ended up					
	with bruise to he	•					
		itting on floor near couch					
		and told staff she did not					
	know how she go						
		n bathroom floor in front					
		against wall by staff. The					
		e resident had increased					
	confusion at that						
		vith bruising on right cic [upper back], lumbar					
	[lower back] and						
		:30 A.M., the resident					
		alking from the bathroom					
		r. The resident's portable					
		ched to the back of her					
	• •	she did not have the nasal					
	l '	esident was also observed					
	to not have her "	call" pendant on. The					
		d at that time that she did					
	not need the oxy	gen or the pendant. The					
	resident indicated	d she needed to "go"					
	because she had	a hair appointment. The					
	resident started to	o propel herself down the					
	1	heelchair. When she had					
		she became tired and					
	requested assista	nce from maintenance					
	_	e her downstairs for her					
	appointment.						
	The most recent	service plan, dated					
		p.m., aacea					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

471H11

Facility ID:

002999 If continuation sheet

Page 19 of 26

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION 00	COM	TE SURVEY MPLETED 1/2011	
	PROVIDER OR SUPPLIER		STREET 9745 C	ADDRESS, CITY, STATE, ZIP DLYMPIA DRIVE RS, IN46038	_	72011
	SUMMARY S (EACH DEFICIEN REGULATORY OR 2/15/11, listed th "Services Provid "Mobility/Transf "Transfers hersel wheelchair, but r transports. Fall r "Behavioral/Moo "No problematic "Other" area of c apartment. No in The actual service facility related to not listed. During the daily 11:30 A.M., the A the opportunity t of a service plan	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) e following in the ed" sections: Pers" area of care: f in and out of needs assist with riskmoderate." od Patterns" area of care: behaviors." are: "Oxygen in nterventions needed." res to be provided by the falls and behaviors were conference on 4/21/11 at Administrator was given o submit documentation or other evidence related be provided by the	9745 0		CODE CORRECTION N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	no additional doc to be provided re behaviors was pr interview at that	ovided for review. In an time, the Director of d they had provided				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	UILDING 00 COMPLETED 04/21/2011			
			B. WIN			04/21/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE LYMPIA DRIVE		
HEARTH	I AT WINDERMERE			1	RS, IN46038		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		w during the initial tour					
	on 4/29/11 at 10 A.M., the Director of						
	ı ~	d Resident #C had					
	receiving Hospic	lls, and recently began					
	1 -	rd for Resident #C was					
	reviewed on 4/21						
		led, but were not limited					
		isease, hypertension, and					
	glaucoma.	iscuse, hypertension, and					
	giadeoma.						
	A. A "Nurse's Note" dated 3/22/11						
	indicated the resi	dent was " found in					
	bed with large an	nt [amount] of					
	undigested vomit	t. Can hear poss					
]	tion with and without					
	1	es bil. [bilateralboth					
		lower posterior lungs.					
	_	radiology service] for					
	chest x ray to rule	•					
	1 '	ent had TIA [transient					
		Nonfocusing eye					
		2 minutes then became					
	more alert"	indian Assessment 1 / 1					
	The Nurses Adm 3/27/11 indicated	ission Assessment dated					
	1 ^ ^	onia. Physicians orders resident was changed on					
		lysphagia diet chopped					
	nectar thick liquid						
	·	otes also indicated falls					
	for Resident #C a						
		ceptionist witnessed					
		sit down in a chair, but					
	1 resident if ying to	Sit down in a chair, but					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 471H11

Facility ID:

002999

If continuation sheet Page 21 of 26

NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE (X4) ID SUMMARY STATEMENT OF DEFICIENCES PREFIX (AB CH) DEFICIENCY MUST BE PERCEDED BY PULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) She missed and accidentally sat on floor. No injuries noted. 11/12/10A.C.N.A. was giving care when resident backed away from her and fell backwards. A small amount of redness was noted to left side. 11/30/10-Resident #C was found in her room, sitting on floor on her buttocks at the foot of her bed. No injuries were noted. 1/18/11The resident was found on the floor, laying on her back. She told staff she was trying to go to the bathroom. No injuries were noted. 3/1/11The resident was found on floor in hallway, and told staff she had hit her head. Neurological checks and vital signs were done.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE COMPI		
NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG She missed and accidentally sat on floor. No injuries noted. 11/12/10A C.N.A. was giving care when resident backed away from her and fell backwards. A small amount of redness was noted to left side. 11/30/10Resident #C was found in her room, sitting on floor on her buttocks at the foot of her bed. No injuries were noted. 1/18/11The resident was found on the floor, laying on her back. She told staff she was trying to go to the bathroom. No injuries were noted. 3/1/11The resident was found sitting up on the floor, inside her room door. No injuries were noted. 4/2/11The resident was found on floor in hallway, and told staff she had hit her head. Neurological checks and vital signs	THIND I LIMIT	or connection	DENTIFICATION NOMBER.					
HEARTH AT WINDERMERE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) she missed and accidentally sat on floor. No injuries noted. 11/12/10A C.N.A. was giving care when resident backed away from her and fell backwards. A small amount of redness was noted to left side. 11/30/10Resident #C was found in her room, sitting on floor on her buttocks at the foot of her bed. No injuries were noted. 1/18/11The resident was found on the floor, laying on her back. She told staff she was trying to go to the bathroom. No injuries were noted. 3/1/11The resident was found sitting up on the floor, inside her room door. No injuries were noted. 4/2/11The resident was found on floor in hallway, and told staff she had hit her head. Neurological checks and vital signs				B. WIN		DDRESS CITY STATE ZIP CODE		
CX4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION COMPLETION CACH DEFICIENCY MUST BE PERCEDED BY FULL. TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG She missed and accidentally sat on floor. No injuries noted. 11/12/10A C.N.A. was giving care when resident backed away from her and fell backwards. A small amount of redness was noted to left side. 11/30/10Resident #C was found in her room, sitting on floor on her buttocks at the foot of her bed. No injuries were noted. 1/18/11The resident was found on the floor, laying on her back. She told staff she was trying to go to the bathroom. No injuries were noted. 3/1/11The resident was found of floor in hallway, and told staff she had hit her head. Neurological checks and vital signs	NAME OF F	PROVIDER OR SUPPLIER						
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REQUIATIONY OR LISC IDENTIFYING INFORMATION) she missed and accidentally sat on floor. No injuries noted. 11/12/10A C.N.A. was giving care when resident backed away from her and fell backwards. A small amount of redness was noted to left side. 11/30/10Resident #C was found in her room, sitting on floor on her buttocks at the foot of her bed. No injuries were noted. 1/18/11The resident was found on the floor, laying on her back. She told staff she was trying to go to the bathroom. No injuries were noted. 3/1/11The resident was found sitting up on the floor, inside her room door. No injuries were noted. 4/2/11The resident was found on floor in hallway, and told staff she had hit her head. Neurological checks and vital signs	HEARTH	AT WINDERMERE						
RECH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) She missed and accidentally sat on floor. No injuries noted. 11/12/10A C.N.A. was giving care when resident backed away from her and fell backwards. A small amount of redness was noted to left side. 11/30/10Resident #C was found in her room, sitting on floor on her buttocks at the foot of her bed. No injuries were noted. 1/18/11The resident was found on the floor, laying on her back. She told staff she was trying to go to the bathroom. No injuries were noted. 3/1/11The resident was found sitting up on the floor, inside her room door. No injuries were noted. 4/2/11The resident was found on floor in hallway, and told staff she had hit her head. Neurological checks and vital signs	(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
she missed and accidentally sat on floor. No injuries noted. 11/12/10A C.N.A. was giving care when resident backed away from her and fell backwards. A small amount of redness was noted to left side. 11/30/10Resident #C was found in her room, sitting on floor on her buttocks at the foot of her bed. No injuries were noted. 1/18/11The resident was found on the floor, laying on her back. She told staff she was trying to go to the bathroom. No injuries were noted. 3/1/11The resident was found sitting up on the floor, inside her room door. No injuries were noted. 4/2/11The resident was found on floor in hallway, and told staff she had hit her head. Neurological checks and vital signs		*				(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	1
No injuries noted. 11/12/10A C.N.A. was giving care when resident backed away from her and fell backwards. A small amount of redness was noted to left side. 11/30/10Resident #C was found in her room, sitting on floor on her buttocks at the foot of her bed. No injuries were noted. 1/18/11The resident was found on the floor, laying on her back. She told staff she was trying to go to the bathroom. No injuries were noted. 3/1/11The resident was found sitting up on the floor, inside her room door. No injuries were noted. 4/2/11The resident was found on floor in hallway, and told staff she had hit her head. Neurological checks and vital signs	TAG	1	·		TAG	DEFICIENCY)		DATE
11/12/10A C.N.A. was giving care when resident backed away from her and fell backwards. A small amount of redness was noted to left side. 11/30/10Resident #C was found in her room, sitting on floor on her buttocks at the foot of her bed. No injuries were noted. 1/18/11The resident was found on the floor, laying on her back. She told staff she was trying to go to the bathroom. No injuries were noted. 3/1/11The resident was found sitting up on the floor, inside her room door. No injuries were noted. 4/2/11The resident was found on floor in hallway, and told staff she had hit her head. Neurological checks and vital signs								
resident backed away from her and fell backwards. A small amount of redness was noted to left side. 11/30/10Resident #C was found in her room, sitting on floor on her buttocks at the foot of her bed. No injuries were noted. 1/18/11The resident was found on the floor, laying on her back. She told staff she was trying to go to the bathroom. No injuries were noted. 3/1/11The resident was found sitting up on the floor, inside her room door. No injuries were noted. 4/2/11The resident was found on floor in hallway, and told staff she had hit her head. Neurological checks and vital signs								
backwards. A small amount of redness was noted to left side. 11/30/10Resident #C was found in her room, sitting on floor on her buttocks at the foot of her bed. No injuries were noted. 1/18/11The resident was found on the floor, laying on her back. She told staff she was trying to go to the bathroom. No injuries were noted. 3/1/11The resident was found sitting up on the floor, inside her room door. No injuries were noted. 4/2/11The resident was found on floor in hallway, and told staff she had hit her head. Neurological checks and vital signs								
was noted to left side. 11/30/10Resident #C was found in her room, sitting on floor on her buttocks at the foot of her bed. No injuries were noted. 1/18/11The resident was found on the floor, laying on her back. She told staff she was trying to go to the bathroom. No injuries were noted. 3/1/11The resident was found sitting up on the floor, inside her room door. No injuries were noted. 4/2/11The resident was found on floor in hallway, and told staff she had hit her head. Neurological checks and vital signs			-					
11/30/10Resident #C was found in her room, sitting on floor on her buttocks at the foot of her bed. No injuries were noted. 1/18/11The resident was found on the floor, laying on her back. She told staff she was trying to go to the bathroom. No injuries were noted. 3/1/11The resident was found sitting up on the floor, inside her room door. No injuries were noted. 4/2/11The resident was found on floor in hallway, and told staff she had hit her head. Neurological checks and vital signs								
room, sitting on floor on her buttocks at the foot of her bed. No injuries were noted. 1/18/11The resident was found on the floor, laying on her back. She told staff she was trying to go to the bathroom. No injuries were noted. 3/1/11The resident was found sitting up on the floor, inside her room door. No injuries were noted. 4/2/11The resident was found on floor in hallway, and told staff she had hit her head. Neurological checks and vital signs								
the foot of her bed. No injuries were noted. 1/18/11The resident was found on the floor, laying on her back. She told staff she was trying to go to the bathroom. No injuries were noted. 3/1/11The resident was found sitting up on the floor, inside her room door. No injuries were noted. 4/2/11The resident was found on floor in hallway, and told staff she had hit her head. Neurological checks and vital signs		room, sitting on	floor on her buttocks at					
1/18/11The resident was found on the floor, laying on her back. She told staff she was trying to go to the bathroom. No injuries were noted. 3/1/11The resident was found sitting up on the floor, inside her room door. No injuries were noted. 4/2/11The resident was found on floor in hallway, and told staff she had hit her head. Neurological checks and vital signs		the foot of her be	ed. No injuries were					
floor, laying on her back. She told staff she was trying to go to the bathroom. No injuries were noted. 3/1/11The resident was found sitting up on the floor, inside her room door. No injuries were noted. 4/2/11The resident was found on floor in hallway, and told staff she had hit her head. Neurological checks and vital signs		noted.						
she was trying to go to the bathroom. No injuries were noted. 3/1/11The resident was found sitting up on the floor, inside her room door. No injuries were noted. 4/2/11The resident was found on floor in hallway, and told staff she had hit her head. Neurological checks and vital signs								
injuries were noted. 3/1/11The resident was found sitting up on the floor, inside her room door. No injuries were noted. 4/2/11The resident was found on floor in hallway, and told staff she had hit her head. Neurological checks and vital signs								
3/1/11The resident was found sitting up on the floor, inside her room door. No injuries were noted. 4/2/11The resident was found on floor in hallway, and told staff she had hit her head. Neurological checks and vital signs			-					
on the floor, inside her room door. No injuries were noted. 4/2/11The resident was found on floor in hallway, and told staff she had hit her head. Neurological checks and vital signs		injuries were not	ed.					
injuries were noted. 4/2/11The resident was found on floor in hallway, and told staff she had hit her head. Neurological checks and vital signs		3/1/11The resid	lent was found sitting up					
4/2/11The resident was found on floor in hallway, and told staff she had hit her head. Neurological checks and vital signs		on the floor, insi	de her room door. No					
hallway, and told staff she had hit her head. Neurological checks and vital signs		injuries were not	ed.					
head. Neurological checks and vital signs		4/2/11The resid	lent was found on floor in					
		•						
were done.		_	cal checks and vital signs					
		were done.						
A "Fall Assessment" completed on 3/2/11		A "Fall Assessme	ent" completed on 3/2/11					
indicated that the resident was at high risk			_					
for falls.		for falls.						
The most recent comice plan dated		The war at war at	aamiiaa mlar datad					
The most recent service plan, dated			-					
3/2/11, listed the following in the "Services Provided" sections:								
Scrvices i tovided sections.		Services Frovid	cu scenons.					
"Mobility/Transfers": "Ambulates		"Mobility/Transf	ers": "Ambulates					
independently. Monitored due to gait		_						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

471H11

Facility ID:

002999 If continuation sheet

Page 22 of 26

PRINTED: 06/15/2011 FORM APPROVED OMB NO. 0938-0391

l	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00		e survey Pleted /2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DRIVE FISHERS, IN46038				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	unsteady at times. "Nutritional Stat good. No current Resident does not Enjoys snacks et. The actual service facility related to problems were not During the daily 11:30 A.M., the stee opportunity to fa service plan to the services to facility for the reswallowing. At the final exist no additional does not be provided reswallowing was an interview at the	us": "Appetite fair to a order for Boost. It like to drink Boost. I [and] Coca Cola." test to be provided by the ofalls and swallowing ot listed. conference on 4/21/11 at Administrator was given of submit documentation or other evidence related to be provided by the esident's falls and on 4/21/11 at 3:20 P.M., cumentation of services elated to falls and provided for review. In that time, the Director of difference of the difference of differen		CROSS-REFERENCED TO THE			

002999

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	1	
			B. WIN			04/21/2	2011
	PROVIDER OR SUPPLIER			9745 O	ADDRESS, CITY, STATE, ZIP CODE LYMPIA DRIVE RS, IN46038		
(X4) ID	SUMMARYS	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE	COMPLETION DATE
FORM CMS-2	shall be disposed appropriate federa disposition of any destroyed medicathe resident's clir include the followi (1) The name of the (2) The name and (3) The prescription (4) The reason for (5) The amount di (6) The method of (7) The date of the (8) The signature the disposal of the (9) The signature disposal of the draward facility failed to documentation of Schedule II conting the initial A.M., the DON in the properties of the clinical reconstruction of the cl	the resident. I strength of the drug. In number. I disposal. I sposed of. I disposition. I dispo	R(Pacility	The procedure for administer crushed medicines will be changed to seperate control schedule drugs from other of being administered. Control drugs will be crushed independantly so they can be disposed of using proper procedures which includes a nurses to witness the destruction of controlled drugs. ID: 002999 If continuation	lled drugs led De wo uction.	06/05/2011

471H11

Page 24 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED				
			B. WING			04/	21/2011		
NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE			STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DRIVE FISHERS, IN46038						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	glaucoma. The Madministration Refused her medication Anot documented following dates: February: 5th, 6th 22nd. March: 5th, 7th, 28th, 30th and 31th and 31	M.A.R. [Medical Record] for February and icated the resident had cations several times. Ativan was refused and on the MAR on the th, 8th, 15th, 19th, and 10th, 11th, 15th, 17th, 1st. Ist. Cumentation related to f Ativan after it was sident for the previously on 4/21/11 at 11:10 A.M., iewed the February and the Pebruary and the properties of the cons were not documented they should have been. In the second of destruction of a colled substance. The they did not use any forms destruction of a noce. Trule relates to Complaint							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM 04/2	(X3) DATE SURVEY COMPLETED 04/21/2011			
NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE			STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DRIVE FISHERS, IN46038						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE					